BDDS
Quarterly Provider Meeting

January 2011

Presentation Highlights

- Transition Monitoring
- Employment First Initiative
- Provider Compliance Surveys
- RHS and Day Services Monthly Reporting Requirements
- Objective Based Allocation updates
- Appeal Process

Transition of Residence Activities

What is a “Transition”?

- For individuals receiving services, it typically includes a change of:
  - physical residence; and/or
  - residential provider

Transition Basics:

- BDDS is placement authority, and no transition shall occur without BDDS' written approval.
- Should a transition occur without BDDS' written approval, all admissions to all service sites of the provider involved will be suspended.
- Each action undertaken during transitions will be documented in DART by the SC, and in INSITE by the CM.
- The CM assumes heightened responsibility for transitions into SL settings.
- The SC assumes heightened responsibility for transitions into all other settings.

Types of Transitions

- From the community (family home) to SL;
- From community to SGL or LP ICF/MR;
- SOF, NF, CF, SGL or LP ICF/MR to SL;
- SOF, NF, CF, SGL or LP ICF/MR to SGL;
- Change of SL provider with change of address;
- Change of SL provider without a change of address
- Change of address, keeping provider and IST;
- Move to new BDDS district with same provider;

more ... types of transitions

- Change of SGL or LP ICF/MR;
- Transition to NF for long term stay;
- Change in SL service provider other than res hab;
- Transition to an ESN;
- Emergency transitions;

NOTE: **Emergency transition is defined** as vacating a residence as a consequence of fire, flood, utility disruption or other similar event rendering the residence uninhabitable.

Highlights: Moves from Community (family home) to SL

- SC completes intake process, and makes referral for CM services if SL
- CM ensures PCP, ISP process; referrals to providers as chosen by individual; completion of POC/CCB
- CM ensures safety of new residence by visiting site and completing an environmental inspection checklist
- CM calls pre-transition conference with new IST for purpose of preparation of transition plan
- SC records decisions during conference on standardized transition plan form, identifying responsible parties & due dates

Continued….

- CM ensures implementation of the transition plan, gathering all info, confirming actions taken, and forwarding the completed plan to the SC.
- CM completes items 1 through 26 of standardized transition monitoring form, ensuring no items identified as a “HOLD” item is marked “no” prior to the transition occurring.
- CM calls transition meeting at least 24 hours prior to the transition date.

Continued…

- CM forwards electronic copy of all documents used during the transition activity to the SC who maintains a file for each individual
- SC approves the transition only after confirming compliance with the transition plan, the EIC, and the transition monitoring checklist.

Highlights: Moves from family home to SGL or LP ICF/MR

- Individuals shall not visit or otherwise consider for transition a home with conditions of participation out of compliance with ISDH.
- SC completes intake process including, eligibility determination for DD services and Medicaid, and makes referral to provider.
- SC completes all steps outlined in previous move to SL setting (i.e. no CM involvement), with addition of signing a RAF within two days of the occurrence of the transition.

Highlights: from SOF, NF, CF, SGL, or LP ICF/MR, to SL

- SC completes intake process including, eligibility determination for DD services and Medicaid, and makes referral to provider.
- SC requests updated information packet from SOF, including master treatment plan, behavior plans, risk plans, medications taken, & a completed supplemental information form.
- Referrals are sent to providers on approved pick list.
- CM completes CCB.

Continued…

- Individuals transitioning from DCS to SL shall utilize any independent funds available prior to requesting community transition funds.
- The CM and SC continue this process using identified responsibilities outlined in previous “moves to SL settings” slides.
- When the transition is from an SOF, the exit transition meeting is held at the sending facility prior to the transition occurring.

Highlights: from SOF, NF, CF, SGL, or LP ICF/MR, to SGL

- SC completes intake process including, eligibility determination for DD services and Medicaid, and makes referral to provider.
- SC requests updated information packet from SOF, including master treatment plan, behavior plan/s, risk plans, medications taken, & a completed supplemental information form.
- Referrals are sent to providers.

more - from SOF, NF, CF, SGL, or LP ICF/MR, to SGL

- The SC continue this process using identified responsibilities outlined in previous “moves to SGL settings” slides.
- When the transition is from an SOF, the exit transition meeting is held at the sending facility prior to the transition occurring.

Highlights: Change of SL provider with change of address

- This change shall not occur until agreed upon during an IST meeting called by the CM.
- The individual must sign a Freedom of Choice form prior to any transition taking place.
- The CM and SC continue using identified responsibilities outlined in previous “moves to SL settings” slides.

Highlights: Change of SL provider with no change of address

- This transition process is the same as “change of SL provider with change of address, with the exception that the CM does not do an EIC checklist.

Highlights: Change of SL address while keeping the same res hab provider and IST

- This change shall not occur until agreed upon during an IST meeting called by the CM.
- The individual must sign a Freedom of Choice form prior to any transition taking place.
- If new residence includes housemates, the CM shall ensure and document that visits to the residence with housemates present are problem free.
- The CM and SC continue using identified responsibilities outlined in previous “moves to SL settings” slides.

Highlights: Change of SL residence to new district, with same provider

- This change shall not occur until agreed upon during an IST meeting called by the CM.
- The individual must sign a Freedom of Choice form prior to any transition taking place.
- If new residence includes housemates, the sending CM shall ensure and document that visits to the residence with housemates present are problem free.
- This process involves communication between the sending and receiving SCs and sending and receiving CMs, and is consistent with previous slides addressing moves to SL settings.

Highlights: change of SGL or LP ICF/MR

- Individuals shall not visit or otherwise consider for transition a home with conditions of participation out of compliance with ISDH.
- SC shall submit for a new LOC
- Upon receipt of a new LOC, the SC shall schedule a pre-transition conference with the IST.
- The SC continues using identified responsibilities outlined in previous moves to SGL or LP ICF/MR settings slides, including a new RAF.

Highlights: to NF for long term stay

- The SC shall call an IST meeting upon learning of the need for a NF admission.
- SC ensures Medicaid eligibility and NF LOC.
- SC schedules a transition meeting, prepares the transition plan, & ensures it is executed.
- If individual was receiving SL services, the CM shall complete a data entry worksheet to terminate waiver.

Highlights: change in SL service provider other than res hab

- CM assists individual with selection of new provider from pic list.
- SC enters the intent to change in DART case notes.
- CM updates CCB to reflect provider change and date of change.
- CCB must be approved prior to change of provider.

Highlights: transition to ESN

- Individuals shall not visit or otherwise consider for transition a home with conditions of participation out of compliance with ISDH.
- Individual must meet ESN LOC to be considered.
- Referral packets will be reviewed and approved by BDDS management staff prior to placement.
- SC sends referral packet to provider.
- SC performs pre-transition monitoring using standardized form.

Continued…

- BDDS staff interviews ESN staff on all shifts to confirm knowledge of individual.
- BDDS reviews staff roster, staff training records, and required staff certification for compliance prior to any transition occurring.

EMPLOYMENT FIRST INITIATIVE
BDDS/VR

EMPLOYMENT FIRST INITIATIVE

GOAL: Maximize integrated community employment for people with developmental disabilities

OBJECTIVE: New people who request services from the BDDS will be referred to VR first to access integrated community employment prior to the provision of any other services.

OBJECTIVE: People who are currently utilizing BDDS services will be assessed to transition from segregated settings into integrated employment whenever possible.

EMPLOYMENT FIRST INITIATIVE

BDDS/VR Partnership

DD individuals will be referred to VR Services

This includes:

Individuals in Services

Individuals on Waitlist

Individuals inquiring about services

EMPLOYMENT DEMONSTRATION PROJECT

- Maximize integrated employment for people with developmental disabilities
- BDDS referrals will also be referred to VR
- Ensure individuals are given an opportunity for employment, or to volunteer in an integrated setting
- Develop demo sites to determine how to maximize employment for people with DD through both VR and waiver
- Increase employer outreach, training and communication
- Evidence informed data to measure success

EMPLOYMENT FIRST: Action Plan

- Data Collection – Baseline data for Demonstration Sites
- Community Meetings – State/Local
- Development of Training Plan
- Employer Outreach Plan
- Evaluation of current “Processes”
- Evaluation of Demonstration Project
- Public Relations and Communication

EMPLOYMENT FIRST: Demo Sites

- Vanderburgh/Evansville
- Monroe/Bloomington
- Howard/Kokomo
- Grant/Marion
- St. Joseph/South Bend

Compliance Evaluation & Review Tool (CERT)

Bureau of Quality Improvement Services

Compliance Survey

- Regulations.
  - Indiana Administrative Code 460, Article 6.
  - Developmental Disabilities, Support Services, and Autism waivers.
  - Indiana Code.
- Survey Schedule.
  - At least once every 3-years.
  - Based on initial provider approval date (INSITE).
  - Reviews based on location of personnel files
- Pilot Project.

CERT Areas of Focus

I: The Provider Meets Qualifications for Waiver Services being Delivered.

II: The Provider has Policies and Procedures to Ensure the Rights of Individuals, to Direct Appropriate Services, and to Support and Manage Employees.

III: The Provider Maintains Employee Information Confirming Key Health, Welfare and Training Issues.

IV: Quality Assurance / Quality Improvement.

Provider Qualifications

- DDRS Approval.
- Example of Services:
  - Transportation.
  - Adult Day Services.
  - Behavioral Support.
  - Community Based Habilitation.
  - Electronic Monitoring.
  - Facility Based Habilitation.
  - Music Therapy.

Policies and Procedures

- Provider Complaint Procedure.
- Reporting Abuse, Neglect, Exploitation and Mistreatment.
- Prohibition of Individual Rights Violations.
- Informing the Individual of Service and Health Status.
- Protocol to Ensure Individual Freedoms.
- Provider Organizational Chart.
- Conflicts of Interest and Ethics.

- Written Personnel Policy:
  - Example requirements:
    - Policy reviewed and updated.
    - Job descriptions with minimum qualifications.
    - Procedure for conducting performance evaluations.
- Written Training Procedures:
  - Example requirements:
    - System for documenting the training that includes the name and qualifications of trainer.
    - Procedure for conducting annual in-service training (e.g., incident reporting and abuse, neglect and exploitation).

Employee Files

- Census Request Form.
  - Electronic and in advance if possible.
- File Selection.
  - Surveyor will select a sample of employee files to review.
- Examples of Content Areas Reviewed.

- Examples of Employee Training,
  - Rights, respect and dignity.
  - Abuse, neglect, and exploitation.
  - Person centered planning.
  - Administering medication.
  - Emergency Drills.
- Examples of Regulatory Checks ,
  - CPR.
  - Negative TB screening prior to employment.
  - Current driver's license.
  - Proof of insurance.
  - Criminal background check.

QA/QI

- Sample areas include:
  - Does the provider have evidence of efforts to improve services in response to the annual survey of individual satisfaction?
  - Does the provider have a process for analyzing data concerning reportable incidents?
  - Does the provider have a process for developing recommendations to reduce the risk of future incidents?
  - Does the provider have a process for reviewing recommendations to assess their effectiveness?

Survey Process

- Scheduling the Survey.
- Conducting the Survey.
- The Survey Report.
- Corrective Action Plan (CAP) Process.
- Verification of CAP Implementation.

Scheduling the Survey

- Initial Contact.
  - 2-3 business days prior to the survey.
  - Brief discussion of the process.
  - Verify office location.
- Documentation Required Prior to Survey Initiation.
  - Census Request form.
    - Lists employees along with services.
  - Documentation noted within Announcement Letter.
    - Must be collected and available at the office location.

Conducting the Survey

- Opening Meeting.
- Selection of Employees from Census Request Form.
  - Provider must gather the identified employees' files for the surveyor(s).
- Documentation Reviewed.
  - Interviews of relevant staff.
- Closing Meeting.
  - Review of findings (not comprehensive).

*** During the survey process we have found that it is helpful to have staff available. This both expedites the review and reduces the risk that we will be unable to locate the required documentation.**

Report of Survey Results

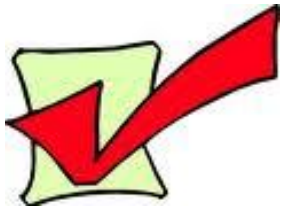
- CERT Survey Summary.
  - Contact information.
  - Services provided under the Waivers.
  - Initial survey summary of results (#s).
- Indicator/Probe Summary.
  - All Indicators and Probes are listed with results.
    - N/A; Met; Not Met (both for initial and follow up).
- CERT Survey Results Template.
  - Findings listed for Probes cited.
  - Designated space for CAP.
- CERT Transmission Data.
  - Important survey dates.

Corrective Action Plan

- A CAP is required for all findings (by Probe).
- CAP due10 Business Days from receipt of letter with report findings.
- CAP includes implementation date.
  - CAP to be implemented within 20 business days of acceptance.
- Review Process:
  - CAP Accepted.
    - Verification to occur within 20 business days.
  - CAP Denied.
    - Reason for denial to be included.
  - Review of 2nd CAP.
    - CAP Accepted.
    - CAP Denied

      Referred to BQIS
  - CAP not Received.
    - **Referred to BQIS.**

CAP Verification



- Will occur 20 Business Days from CAP Acceptance.
- Location.
  - May or may not be onsite.
- Documentation.
  - Support of CAP implementation.
  - May need to review additional employee files (or portions of the files for review).
- Disposition:
  - CAP Implemented – Survey closed.
  - CAP Not Implemented – **Referred to BQIS**.

Resource/Contact Information

BQIS

- Becky Selig, BQIS Director
  - Becky.Selig@fssa.in.gov
  - (317) 234-1147.
- Shelly Thomas, BQIS Contract Liaison
  - Shelly.Thomas@fssa.in.gov
  - (317) 234-2707.
- BQIS E-Mail: BQIS.Help@fssa.in.gov
- Website: www.ddrs.in.gov

Liberty of Indiana

- Christopher Baglio, Liberty of Indiana Director
  - Christopher.Baglio@fssa.in.gov
  - (317) 974-0980.
- Michael Thomas, Liberty of Indiana Assistant Director
  - Mike.Thomas@fssa.in.gov
  - (317) 974-0980.

Monthly Summaries for RHS & DAY

Monthly Summaries for RHS & DAY

- When RHS & DAY program services are delivered, providers must complete a monthly summary for each consumer served
- The narrative summary will describe the consumer's activities and document the consumer's progress toward outcomes listed on the Individualized Support Plan (ISP)

Monthly Summaries

The summary shall also include a high level summary of any issues affecting the health, safety and welfare of the consumer and requiring intervention by a healthcare professional, case manager, behavioral support service provider or BDDS staff member

Monthly Summaries for RHS & DAY

- The monthly summary must be submitted to the case manager for review
- The case manager will then present the monthly summaries at the next meeting of the Individualized Support Team (IST) for discussion.
- The IST will either accept the progress made or agree to service, ISP or outcome modifications

Monthly Summaries for RHS & DAY

- Failure to complete, maintain or submit the summaries as described will result in an incident being filed by the case manager

OBA Updates

Development of the Objective Based Allocation Method

- In 2007, DDRS and a group of advocates, providers, and industry professionals began the research and development of an objective based allocation method.
- External partners included representatives from the ARC, INARF, INABC, Milliman, and IPMG
- Development strategy included baseline research, provider cost reporting, modeling, assessment validation, pilots, and best practices.
- Modeling was used to determine the parameters for Algorithm development (ALGOs)

ICAP Assessment & ALGO Development

- The nationally recognized Inventory for Client and Agency Planning (ICAP) was selected to be the primary tool for individual assessment.
- The ICAP assessment determines an individuals level of functioning for Broad Independence and General Maladaptive Factors.
- The ICAP Addendum, commonly referred to as the Behavior and Health Factors determines an individuals level of functioning on behavior and health factors.
- These two assessments determine an individual's overall ALGO level which can range from 0-6. ALGOs 0 & 6 are considered to be the outliers representing those who are the highest on both ends of the functioning spectrum.

ALGO Needs Descriptors

Level	Descriptor
0 Low	**High level of independence (Few Supports needed). No significant behavioral issues. Requires minimal Residential Habilitation Services.**
1 Basic	**Moderately high level of independence (Limited supports needed). Behavioral needs, if any, can be met with medication or informal direction by caregivers (through the use of Medicaid state plan services). Although there is likely a need for day programming and light Residential Habilitation Services to assist with certain tasks, the client can be unsupervised for much of the day and night.**
2 Regular	**Moderate level of independence (Frequent supports needed). Behavioral needs, if any, met through medication and/or light therapy (every one to two weeks). Does not require 24-hour supervision – generally able to sleep unsupervised – but needs structure and routine throughout the day.**
3 Moderate	**Requires full-time supervision (24/7 staff availability) for medical and/or behavioral needs. Behavioral and medical supports are not generally intense and can be provided in a shared staffing setting**
4 High	**Requires full-time supervision (24/7 frequent and regular staff interaction, require line of sight) for medical and/or behavioral needs. Needs are moderately intense, but can still generally be provided in a shared setting.**
5 Intensive	**Requires full-time supervision (24/7 absolute line of sight support). Needs are intense and require the full attention of a caregiver (1:1 staff to individual ratio). Typically, this level of services is generally only needed by those with intense behaviors (not medical needs alone).**
6 High Intensive	**Requires full-time supervision (24/7 more than 1:1). Needs are exceptional and for at least part of each day require more than one caregiver exclusively devoted to the client. There is imminent risk of individual harming self and/or others without vigilant supervision.**

Objective Based Allocation Components

- The Objective Based Allocation (OBA) is determined by combining the Overall ALGO (determined by the ICAP and ICAP addendum), Age, Employment, and Living Arrangement
- The Stakeholder Group which included the aforementioned external partners designed a building block grid to build the allocations.
- The building block grid was developed with the following tenets playing key roles: Focus on Daytime Programming; Employment; Community Integration; and Housemates

	ALGO Level						
Individual RHS Daily Hours	**0**	**1**	**2**	**3**	**4**	**5**	6
	Low	**Basic**	**Regular**	**Moderate**	**High**	**Intensive**	**High Intensive**
Living with Family	0.2	2	3	4	5	6	6
Living Alone	0.2	2.6	6	9	11.7	21	21
Living with One Housemate	0.2	2.6	5.3	7.8	11	12	12
Living with Two Housemates	0.2	2.6	4.6	7.8	10.1	11	11
Living with Three Housemates	0.2	2.4	4.3	7.3	9.4	10	10
BMAN Reserve (Annual hrs)	0	0	36	72	108	144	144
Day Service Reserve ($/Yr)							
Not Attending School	$ 10,500.00	$ 10,500.00	$ 10,500.00	$ 10,500.00	$ 10,500.00	$ 18,000.00	$ 18,000.00
Attending School or under 19yrs.	$ 5,500.00	$ 5,500.00	$ 5,500.00	$ 5,500.00	$ 5,500.00	$ 5,500.00	$ 5,500.00

Emphasis on Housemates

- Housemate living arrangements provide the benefit of shared residential staffing and assist with lowering several costs of living (rent, utilities, etc.)
- Housemates also provide psychosocial and esteem benefits to individuals.
- The new OBA is designed to even out budget inconsistencies among housemates by eliminating the ideology where one high budget housemate carries the residential service hours for the others.

Implementation of Objective Based Allocations

- Individuals will receive their new OBA on their annual renewal date. The first group will be the January 1st population.
- Over the course of 12 months, all waiver participants will be transitioned to an OBA when their waiver is up for annual renewal.
- Allocations will receive a pre-release review focusing on individuals whose allocations drop or increase significantly from their previous cost comparison budget.
- An in-depth review and appeal process is available to teams wishing to dispute their oba.

Review Requests & Appeals

- Individual teams can request a PAR (Personal Allocation Review) through their case manager. The review is conducted by the PAR unit in BDDS Central Office.
- Individual teams will be asked to review the ICAP and ICAP addendum as well as provide any other supporting documentation supporting an individual's need for placement in a different ALGO level.
- The PAR unit will review submitted documentation as well as the Person Centered Planning Document, Individualized Service Plans, Behavior Support Plans, High Risk Plans and any other collateral documentation needed to analyze the individual's Algo.

Appeals

- After a PAR review has been completed. Recommendations will be submitted to the case manager with the findings of the review which may include changing of ALGO assignment or recommendation for housemates or other services.
- Only 1 PAR via BRQ will be considered at annuals.
- Because housemate annuals may vary by date. A review of all housemates may be requested prior to their annual date.
- An individual or their legal representative may appeal the ICAP assessment if they feel it is inaccurate. BDDS has a policy that determines the parameters for validating an ICAP Assessment. The regular appeal process should be followed to dispute an ICAP. The appeal process will be discussed in later slides.

PAR Requests using BRQ

•The BRQ (Budget Review Questionnaire) is the mechanism for submitting the PAR Request. The Case Manager shall submit all the supporting information provided by the team.

•The following qualifiers must be met to submit a BRQ:

Living Arrangement has changed
Medical Condition(s) have changed
Behavioral Condition(s) have changed
Finished with School
ALGO level needs to be reviewed
Health or Medical Condition negates Day Program

BRQ

Series of questions to assist in the review of PAR. Make sure any disagreement with the ICAP Addendum are provided.

- What need are not currently met?
- What documentation supports the request for the Allocation Review? If a specific incident or several incidents support the request, please briefly describe how the request addresses the incidents. Also include other specific conditions or situations.
- Does the consumer share the requested services with any other consumers? If yes, please list the names of the housemates.
- Please describe the impact of the unmet needs on the consumer's health and welfare.
- What strategies has the team implemented to meet the needs of the consumer within the current allocation (i.e. rearranging house or service mix, exploring natural supports)?

BRQ questions are reviewed by the District Before being submitted to PAR. All questions must be fully answered.

What is reviewed by PAR?

- DDP, ISP, Risk and Behavioral Plans
- Case notes
- Incident Reports
- RHS or Behavior Weekly Summaries
- Medicaid Traditional and PA other medical services.
- All other collateral documents pertaining to individuals current state.

Transitioning to Housemate Arrangements

- Because the ideal housemate arrangement is three person, a transition plan may need to be in place for an individual.
- The transition plan includes a six month window of funding to enable the individual and team to find suitable living arrangements and housemates.
- A case manger may request additional support during the search and move in of a housemate via BMR.

Appeals

Appeal Process (OBA, CCBs)

- The consumer/legal guardian has the right to appeal any waiver-related decision of the state within 30 days of Notice of Action (NOA).

- A Notice of Action (NOA) is issued with the release of each state decision pertaining to a Plan of Care/Cost Comparison Budget (CCB).

- Each NOA contains the appeal rights of the consumer as well as instructions for filing an appeal.

- For a consumer who desires to appeal the objective based allocation received, it is necessary to first allow the Case Manager to submit a CCB using the objective based allocation funding amount.

- Once a decision is rendered by the State, whether the CCB is approved or denied, the consumer/guardian will receive the NOA required for the appeal.

The Right to Appeal and Have a Fair Hearing:

If your application or service is denied, you may file an appeal within 30 days of the decision date shown on this notice. The time limit for filing an appeal is extended by 2 days if this notice is received by mail. Your Home and Community Based Services (HCBS) benefits will continue if you file an appeal within the required time frame of the decision notice. If you appeal and your benefits are continued and you lose the appeal, you may be required to repay assistance paid in your behalf pending the release of the appeal hearing.

How to Request an Appeal:

•If you wish to appeal this decision, you may request an appeal within 30 days of the date of this notice. The time limit for filing an appeal is extended by 3 days if this notice is received by mail. To file an appeal, please sign, date and return the Hearings & Appeals copy of this form to:

Office of Hearings and Appeals
MS 04
402 W. Washington St. Room E-304
Indianapolis, IN 46204

If you are unable to sign, date, and return this form to the above mentioned address, you may have someone assist you in requesting the appeal.

•You will be notified in writing by the Indiana Family and Social Services Administration, Hearings and Appeals office of the date, time, and location for the hearing. Prior to, or at the hearing, you have the right to examine the entire contents of your case record maintained by the Case Manager.

•You may represent yourself at the hearing or you may authorize a person to represent you, such as an attorney, relative or other spokesperson. At the hearing you will have full opportunity to bring witnesses, establish all pertinent facts and circumstances, advance any arguments with interference and question, or refute any testimony or evidence presented.